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g. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by the DRG payment method. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC payment method.

b. AIDS-Related Services

AIDS-related inpatient services are exempt from DRG payment methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), and other Human Immunodeficiency Virus (HIV) infections.

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

d. Level B Inpatient Acute Physical Medicine and Rehabilitation Services

Level B Inpatient Acute Physical Medicine and Rehabilitation (PM&R) services are exempt from DRG payment methods. Level B PM&R services are reimbursed using a fixed per diem rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient.

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Hospitals and skilled nursing facilities must request and receive a Level B PM&R designation. Care is authorized and provided on a case-by-case basis.

e. Bone Marrow And Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

f. Chemically-Dependent Pregnant Women

Hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method.

g. Long-Term Acute Care Program Services

Long-Term Acute Care (LTAC) services are exempt from DRG payment methods. LTAC services are reimbursed using a fixed per diem rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through an inflation adjustment. Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

h. Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned.

Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned are reimbursed using the RCC payment method.

i. Trauma Center Services

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available.

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This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

Trauma centers services will be reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. Currently, the fund is providing reimbursements at an increased percentage of the base Medicaid rate for hospital care and physician care delivered to fee-for-service Medicaid trauma patients with an Injury Severity Score (ISS) of 16 or greater.

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below, the payment to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital; or, the appropriate DRG payment.

If a client is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

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The hospital that ultimately discharges the client is reimbursed the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge will be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case.

11. Administrative Days Policy

Administrative days are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.

For a DRG payment case, administrative days are not paid until the case exceeds the high-cost outlier threshold for that case. If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the hospital may be reimbursed at the Administrative Day per diem rate from the date of admission. The administrative rate is adjusted November 1.

For DRG exempt cases, administrative days are identified during the length of stay review process.

12. Short Stay Policy

Stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are reimbursed under the DRG payment methods.

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13. Medicare Crossover Policy

Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medical Assistance. For clients, the state considers the Medicare DRG payment to be payment in full. The state will pay the Medicare deductible and co-insurance related to the inpatient hospital services. Total Medicare and Medicaid payments to a provider cannot exceed the DSHS's rates or fee schedule as if they were paid solely by Medicaid using the RCC payment method.

In cases where the crossover client's Part A benefits including lifetime reserve days are exhausted and the Medicaid outlier threshold status is reached, the state will pay for those allowed charges beyond the threshold using the outlier policy described above.

14. Fixed Per Diem Rate

A fixed per diem rate is used to reimburse for the Level B Acute PM&R and LTAC programs. The fixed per diem rate is established through identification of historical claims costs for the respective services provided. Predetermined Vendor rate adjustments are made annually. For SFY 03 the vendor rate adjustment made to the fixed per diem rate for qualified vendors is 1.5%.

15. Third-Party Liability Policy

For DRG cases involving third-party liability (TPL), a hospital will be reimbursed the lesser of the DRG billed amount minus the TPL payment amount or the applicable DRG allowed amount for the case minus the TPL payment amount. For RCC cases involving TPL, a hospital will be reimbursed the RCC allowed amount minus the TPL payment amount.

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16. Day Outliers:

Section 1923(a)(2)(C) of the Act, requires the state to provide payment adjustment for hospitals for medically necessary inpatient hospital services involving exceptionally long length of stay for individuals under the age of six in disproportionate share hospitals and any hospital for a child under age one. A hospital is eligible for the day outlier payment if it meets the following:

a. Any hospital serving a child under age one or is a DSH hospital and patient age is 5 or under.

b. The patient payment is DRG.

c. The charge for the patient stay is under $33,000 (cost outlier threshold).

d. Patient length of stay is over the day outlier threshold for the applicable DRG.

The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

The Day Outlier Payment is based on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate. Day outliers will only be paid for cases that do not reach high cost outlier status. A patient's claim can be either a day outlier or a high cost outlier, but not both.

17. Trauma Care Enhancement

The enhancement consists of paying an increased percentage of the standard DRG or RCC payment for trauma care services rendered. The RCC enhanced payment can be no more than the billed charges on the claim. The DRG enhanced payment can exceed the billed charges, but the aggregate of payments for all DRG paid claims cannot exceed the aggregate that Medicare would pay for the same DRG claims in the year.

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D. DRG COST-BASED RATE METHOD

The DRG cost-based rate is a calculated hospital specific dollar amount that is multiplied by the applicable DRG weight to produce the DRG payment. The rate has three components (operating, capital and direct medical education).

The rate is established on the basis of hospital's average cost for treating a Medicaid patient during a base period. This amount is adjusted for the hospital's case mix and updated for inflation.

1. Base Period Cost and Claims Data

The base period cost data for the rates are from hospitals' Medicare cost reports (Form HCFA 2552) for their fiscal year (FY) 1998. Cost data that was desk reviewed and/or field audited by the Medicare intermediary before the end of the rebasing process was used in rate setting when available.

Three categories of costs (total costs, capital costs, and direct medical education costs) are extracted from the HCFA 2552 for each of the 38 allowed categories of cost/revenue centers used to categorize Medicaid claims.

Nine categories are used to assign hospitals' accommodation costs and days of care, and 29 categories are used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1998 period are extracted from the state's Medicaid Management Information System (MMIS).

Department of Health Composite Hospital Abstract Reporting System (CHARS) claims representative of services covered and provided by Healthy Options managed care plans are also extracted. Line item charges from claims are assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data are also used to compute hospitals' FY 1998 case-mix index.

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2. Peer Groups & Caps

The Medical Assistance Administration's (MAA's) peer group methodology for peer groups A and B is aligned with that of Washington State Department of Health's (DOH) and is adopted for rate-setting purposes. MAA's peer grouping has four classifications: Group A, which are rural hospitals paid under an RCC methodology; Group B, which are urban hospitals without medical education programs; Group C, which are urban hospitals with medical education programs; and Group D, which are specialty hospitals. DOH's peer group 3 combines the hospitals located in MAA's peer groups C and D.

Indirect medical education costs are removed from operating and capital costs, and direct medical education costs are added. Peer group caps for peer groups B and C are established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceed the 70th percentile of the peer group are re-set at the 70th percentile cap. The hospitals in peer group D are exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons.

Changes in peer group status as a result of DOH and MAA approval or recommendation are recognized. However, in cases where post-rate calculation corrections or changes in individual hospital's base-year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus have an impact on the peer-group cap, the cap is updated only if it results in a 5.0 percent or greater change in total Medicaid payment levels.

3. Conversion Factor Adjustments

Indirect medical education costs are added back into costs before application of any inflation adjustment. A 0.008219 percent per day inflation adjustment (3.0 percent divided by 365 days) is used for hospitals that have their fiscal year ending before December 31, 1998. A 9.1086 percent inflation adjustment is used for the period from January 1, 1999 to October 31, 2001.

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Annually all cost based conversion factors are adjusted by a predetermined vendor rate adjustment.

4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that are not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies are established to estimate these costs. Per diem proxies are developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital is calculated based on the Medicaid cases for each hospital during its F\ 1998 cost report period.

6. Indirect Medical Education Costs

An indirect medical education cost is established for operating and capital components in order to remove indirect medical education related costs from the peer group caps. To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds is multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio is multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component.

The indirect medical cost is trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

7. Rate Calculation Methodology

Step 1: For each hospital, the base period cost data are used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories.

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These costs are divided by total hospital days per category to arrive at a per day accommodation cost. The accommodation costs per day are multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data are also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs are divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

These ratios are multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs are combined to derive the operating, capital and direct medical education's components. These components are then divided by the number of Medicaid cases to arrive at an average cost per admission.

Step 4: The three components' average cost per admission are next adjusted to a common fiscal year end (December 31, 1998) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital is removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost is set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in are next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1999 through October 31, 2001. The outlier set-aside factor is then subtracted to arrive at the hospital's January 1, 2001 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

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Those in-state and border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

8. Border Area Hospitals Rate Methodology

Border area hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Couer d'Alene, Lewiston, Moscow, Priest River and Sandpoint.
These hospitals' cost-based rates are based on their FY 1998~~3~~ Cost Reports and FY 1998 claims, if available. Those border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to January 1, 2001. A change in ownership does not constitute the creation of a new hospital. New hospitals' cost-based rates are based on the peer group average final conversion factor for their hospital peer group, less the outlier set aside factor.

10. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's. Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act.
Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

E. RCC RATE METHOD

The RCC payment method is used to reimburse Peer Group A hospitals for their costs and other hospitals for certain DRG exempt services as described in Section C.8.

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The RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and border area hospitals which the State determines have insufficient data or Medicaid claims to accurately calculated an RCC ratio, is also the average of RCC ratios for in-state hospitals.

Hospital's RCC ratios are updated annually with the submittal of new HCFA 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

F. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program, a hospital must meet the Medicaid one-percent utilization to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component. All the DSH payments will not exceed the State's DSH allotment.

To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost.

Cost is established through prospective payment methods and is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.